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ABSTRACT

Managed care has prompted a metamorphosis of mental health care. Since practitioners' responses to these changes are unclear, this study examines the opinions of 44 randomly selected psychologists and psychiatrists. Each participant received a packet in the mail that contained a cover letter, a three-page questionnaire, and a self-addressed stamped envelope. Questionnaire items were developed in conjunction with managed care providers. Items were seen as representative of concerns reflected in scientific journals, addressing issues such as utilization review, appeals, patient confidentiality, and short-term therapy. Respondents' median number of years of clinical experience was 18 and their mean number of years working in managed care was 5. Managed care's impact on the practices of psychologists versus psychiatrists was also examined. Most of the respondents, (57%) had Ph.D. level professional training while 17% held an M.D. Results revealed a strong negative attitude toward managed mental health care, particularly the utilization review process. However, despite this dissatisfaction, only a minority questioned utilization reviewers credentials. Participants also reported economic difficulties, such as a significant decline in referrals from primary care physicians. No strong attitudinal differences regarding managed care were revealed between Ph.D.s, M.D.s, and Master's level psychologists. Contains 19 references. (RJM)

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PSYCHIATRISTS' AND PSYCHOLOGISTS' ATTITUDES TOWARD MANAGED CARE

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ABSTRACT

The mental health care delivery system is undergoing a metamorphosis of unprecedented proportion as a result of managed care. Few empirical assessments of practitioner response exist. Utilizing managed care provider and telephone directories, 100 psychologists and psychiatrists were anonymously surveyed by mail. Questions concerned utilization review, appeals, patient confidentiality and short-term therapy. The impact of managed care on the practices of psychologists vs. psychiatrists was examined. A median split was used to distinquish practitioners on the basis of their length of experience with managed care; responses of these two groups were compared.

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Introduction

We are in the midst of a health care revolution which is rapidly replacing the traditional fee-for-service model of health care with managed care organizations. Frank (1993) identified some of the factors which have fueled this reform movement.

The factors cited by Frank basically stem from the fact that health care markets have not traditionally been competitive. As a consequence, few forces operated to prevent runaway inflation within health care. This has resulted in an environment in which costs reduce access to medical care. These rising costs also combined with slow productivity growth to absorb much of the growth of employees' real compensation and create distortion and inflexibility in the labor market.

David Mechanic et al. (1995) researched and assessed the management of mental health and substance abuse services, and described the state of the art as well as the early results. "The designation 'managed care' encompasses a wide range of organizational forms, financing arrangements, and regulatory devices that vary in their impact on patient care." There is an increasing demand for managed care strategies for the delivery of mental health and substance abuse services. However, because managed care is so heterogeneous and complex, it is difficult to effectively evaluate its impact on mental health and substance abuse services.

The authors defined the broadest use of the term "managed care" as "organizational arrangements that alter treatment decisions that would otherwise have been made by individual patients or providers." They then grouped these organizational arrangements into three broad categories, all of which appear in a variety of forms but have common defining characteristics: prepaid health plans (HMOs), utilization management by third-party organizations (UROs), and high-cost case management. HMOs are becoming one of the most common types of managed care organizations which service people with psychiatric disorders. However, most HMOs only cover acute care, and provide only limited coverage for chronic mental illness in their standard plan for private enrollees.

The main goal of managed care is to limit unnecessary medical services without denying necessary and efficacious medical care. This goal is achieved by a case manager who is responsible for treatment decisions regarding expensive diagnostic procedures, inpatient admission, or referral to specialists, or by a third party, who reviews such decisions and assesses their validity. These treatment decisions can be influenced by any one or all of the following: budget constraints, financial incentives for providers, and review of treatment plans against criteria defining appropriate care. These influences can alter the treatment practices of therapists in MCOs.

The research on the impact of managed care on the use, quality, and cost of mental health services addresses three central issues:

1. What we can expect of the typical managed care plan covering mental health and substance abuse?

2. What potential is offered by the best and most effective versions of managed care?

3. What risks are associated with less careful applications of managed care?

Prepaid group practices lower cost by reducing inpatient care. However, this is not always associated with increased outpatient care. They also lower costs by substituting costly outpatient services with less intensive and less expensive outpatient services. The use of utilization management generally lowers costs by reducing hospitalizations, and the research seems to indicate that it has only been effective in cases with groups that had previously experienced above-average expenditures for these services. Managed care plans are believed by many to have the potential to improve the standards of appropriate treatment in areas where practice variations are large.

However, there is concern that managed care may be applied to the treatment of the mentally ill and substance abusers in ways that neglect the special needs

of these populations. For example, there may be enrollees in these plans that are not identified and diagnosed with a mental illness, and individuals with a more serious mental illness may be treated less effectively. While it is easy to find anecdotal examples of both outstanding and distressing managed care practices, few well controlled studies exist. This makes it difficult to assess with any certainty the consequences of managed care.

More consistent and compehensive use of outcome measures is needed to evaluate the impact of managed care practices accurately. Current measurements generally overlook the burdens of untreated mental illness on families and neighborhoods, and fail to assess the social costs of community living for people with mental illness. Research is sorely needed to develop a more complete picture managed care effects and its success in actualizing its potential for achieving efficiency while enhancing the quality of service delivery.

Questions have been raised about the ethical and practical soundness of current managed care systems because they pursue contradictory goals. Marc Rodwin(1995) wrote about the impact these goals may have on patients. The goal of managed care is to control costs, and increase treatment efficiency and availability as well as quality. This is accomplished in several ways. Physicians must report to case managers or

gatekeepers who, guided by managed care policies, restrict the physicians' treatment decisions and control referrals for specialty services. Financial incentives are used to influence providers to choose the least expensive mode of therapy. Case managers, upon reviewing medical records, have the right to deny physicians payment for any medical care they deem unnecessary. Managers, both implicitly and explicitly, ration certain services.

Although the goals of managed care purport to be in the best interest of the patient, often times patients needs conflict with the financial interests of the managed care organization. Managed care organizations have the following objectives: reduce expenditures and the use of services, increase efficiency, eliminate unnecessary and potentially harmful treatments, provide better or more desirable treatments for patients, expand the range of services offered, and improve patients' quality of life.

These objectives can jeopardize the integrity of the physicians' decisions as a fiduciary for the patient, and cause divided loyalties because of competing obligations. A case manager, in order to reduce expenditures and the use of services, may require a physician to use a less expensive and less effective treatment, that the physician knows may be detrimental to the patient's quality of life. The press for increased efficiency may

cause the patient to receive less individual attention. Conversely, the reduction of medical costs theoretically will benefit patients in that it will lower their premiums.

Informed consent, which requires physicians to explain to patients the choices available, the risks and benefits of any proposed treatment, and any alternatives, is being compromised by managed care because providers do not inform patients of the their restricted clinical choices. Public policies need to be set up in order to mitigate these conflicts of interests.

Managed mental health care (MMHC) is reshaping clinical practices to focus on the goals of efficacy and efficiency. Norman Winegar states that standardization of products or services and increased productivity will be two inevitable outcomes of the MMHC, along with new clinical service marketing strategies, increased oversight of treatment plans and service delivery, better accountability for effectiveness and client satisfaction; and increased services within a coordinated network of health care professionals and facilities(1993).

Relatively few studies have investigated how providers are adapting to managed care. Carol Austad et al., (1993) conducted a study to see how the HMO has affected the practice styles of psychotherapists. A total of 294 therapists completed the 4-page survey. The respondents formed an aggregate of psychologists,

psychiatrists, and social workers. The questionnaire contained objective and open-ended questions pertaining to psychotherapy models, psychotherapy orientation, practice habits, quality of work, work conditions, stresses, burnout and its prevention, graduate training, evolution of practice style and the development of self as a person.

Since the majority of managed care plans are now covering mental health services, there will be a burgeoning number of people receiving mental health care through MCO's. Critics assert that the quality of mental health treatment is at risk because traditionally trained psychotherapists have to adapt their practice styles to the HMO. Making these practice style accommodations can prove to be very challenging for therapists. The Austad, et al. subjects average number of years of HMO experience was 5.4 and the mean age was 42.5 years. The average number of pre-HMO experience was 6.7. 58.3% of the participants stated that they "happened into" the HMO. The majority also stated that they had little knowledge of managed care prior to employment. Only 9.2% said they knew a little about managed care. Most of the therapists stated that a large part of their work day consisted of direct client contact, averaging over 5.1 "back to back" psychotherapy sessions. The mean number of hours per day they spent conducting back to back individual psychotherapy was 5.7 , which was more than the number of

hours they believed it was possible to perform at a level of maximum effectiveness (mean = 5.2)

The subjects were asked to rate a number of variables on a 1 to 10 point scale. Ratings of the level of therapy effectiveness increased significantly after working in the HMO (m = 7.6) compared to when they first started (m =6.6). Ratings of the quality care personally rendered did not change significantly. The data indicated that HMO therapists believed that the quality of mental health care was higher at the HMO than what is offered in the community.

However, the ratings of the following declined significantly over time: overall work conditions, clinical load, professional fulfillment, job satisfaction and enjoyment of work. Therapists looked forward to client cancellations more so then when beginning at the HMO. The average number of years, as reported by HMO therapists, that it was possible for a therapist to work at the HMO was 26.3 years on a part time basis but only 11.8 years on a full-time basis. HMO therapists reported that their actual salary was significantly lower than what they thought they ought to be receiving.

Almost half of the subjects reported that their biggest stressor was the number of patients to be "managed". When dormant patients increasingly become active, therapists felt forced to work with fewer resources and less time.

As far as psychotherapy and practice style, the majority of therapists believed that working at the HMO had influenced how they practiced. Only 9.8% believed that their practice style was not influenced by working at the HMO. 68.2% of the subjects stated that the most important characteristic of a good HMO therapist was "competence in short term therapies". 60.7% of the therapists reported that they were not adequately prepared in graduate school for this type of work. Carol Austad et al., concluded that the time of staff selection, consideration should be given to whether or not the therapist possesses the values and models of therapy that are compatible with the philosophy, structure, and needs of the HMO. The more closely matched in values, and the more short term and eclectically-oriented the therapist, the easier it may be to accommodate to the HMO style of practice.

Karg-Bray, et al.(1996) found that clinicians with greater managed care experience espoused more favorable managed care attitudes than those with less experience.

According to John K. Iglehart, treatment outcomes, patient satisfaction and the quality of care are topics which have not been adequately addressed in assessment studies of managed care organizations. While cost containment and profitability have been toted time and again in studies, what mental health behavioral health care is based upon - the health and lives of the patients

- have appeared to be ignored. Cost savings obtained at the expense of quality becomes a liability, not an asset.

The present study attempted to assess some of the specific ways in which managed care has affected the practice of psychotherapy.

Methods

Subjects

One hundred randomly selected mental health care professionals, who practice in the urban and suburban areas of two northeastern states, were invited to record their responses on a multiple choice style questionnaire of 29 items on the topic of managed mental health care. Names and addresses were selected from managed health care and telephone directories.

Apparatus

Each subject received a research packet which included a cover letter, a three-page questionnaire, a flavor-sealed tea bag, and a self-addressed stamped return envelope. The questionnaire items were developed on the basis of consultation with current managed care
providers and were selected as representative of common concern reflected in scientific journals.
Respondents were assured that their anonymity would be maintained.

Procedure

The research team utilized a four week time period during March and April of 1996. Potential subjects were identified through listings of mental health clinicians in managed care and telephone directories. Duplicate listings were eliminated. Each research team member received a portion of this list from which twenty mental health care professionals received research packets. Pooled data from completed questionnaires was entered into the computer for analysis.

The areas of interest concerning utilization review, appeals, patient confidentiality and short-term therapy were addressed in questions one through seventeen. Questions eighteen through twenty-nine concentrated on demographic information which included sex, age, professional training, years of managed care experience, therapeutic orientation and psychological services provided to patients.

Results

Forty-four mental health care professionals completed the 29 question query. Of the sample, there were 21 women and 23 men (x age 47 years; range 23 to 63 years). Respondents had a median of 18 years clinical experience and a mean of five years experience in managed care. The majority of respondents (57%) had Ph.D. level professional training, while 17% recorded

their degree classification as M.D.; the remainder were masters levels professionals. Therapeutic orientation was identified as being primarily cognitive/behavioral (57%). When asked to identify a second treatment emphasis, 46% chose eclectic and 23% chose solution-focused.

In addressing the issue of utilization reviewer qualifications, a majority of respondents (88%) viewed utilization reviewers as insufficiently qualified; although most (63%) did not question the credentials of the utilization reviewer. Overall, 91% favored certification of the utilization reviewer by the Insurance Department. In fact, 100% of respondents with managed care experience viewed certification as necessary. Twenty-four percent of the subjects perceived the utilization review as wasteful, and an additional 55% agreed that utilization review was rarely helpful in regulating the treatment patients receive. This coincided with the reported 71% who felt utilization review had an adverse effect on patient care and 47% who viewed the appeal process as inefficient. On the issue of client referrals following an appeal, 77.4% rarely, if ever, experienced a reduction.

The pattern of negativity on the part of the respondents continued when the majority of the sample (85%) stated that confidentiality of patients was being

compromised by managed mental health care. When questioned of their knowledge of Senate Bill 828, which addressed these issues, most (54%) were unaware of its existence. A majority of the sample (71%) reported exaggerating patients' symptoms in order to obtain authorization for additional sessions.

In assessing their own effectiveness in providing short-term therapy, 100% of the respondents believed they were at least somewhat effective. Twenty-one percent of these professionals reported obtaining follow-up information on their patients. Additionally, 41% see general provisions of short-term therapy as somewhat to extremely effective for most patients.

On items addressing the economic impact of managed care on mental health care professionals, 50% experienced a moderate to dramatic decrease in referrals from primary care physicians, while 14% cited an increase. Following denial of additional sessions by the managed care organization, 56% of providers have seen patients for a reduced fee. The majority (91%) had had patients who terminated treatment prematurely due to denial of sessions.

Between-group t-test comparisons revealed no significant differences for high and low managed care experienced clinicians on any of the dependent variables. T-test comparisons revealed a tendency for clinicians who exclusively treat the worried well to

express greater dissatisfaction of managed mental health care ($p=.06$).

Discussion

The present study consistently showed the strong negative attitudes of mental health care providers toward managed mental health care. Directionally adjusted scores on the items were totaled to create a summary measure of dissatisfaction with managed care. Respondents were particularly critical of the utilization review process. Despite this dissatisfaction, only a minority questioned utilization reviewer credentials when the opportunity presented itself, and few had knowledge of a proposed Senate bill which would regulate the credentialing and certification of utilization reviewers.

A possible explanation for respondents' lack of knowledge of the aforementioned Senate bill may be the inability of professional mental health associations to inform their members about initiatives in health care reform. These associations could best serve their members by legislative alerts, mailings and computer networking. Broad based support to assist legislators in defeating the powerful insurance lobby and adopting legislature could be garnered. Alternatively, mental health care providers may be unable to peruse communications issued by these associations as a result of increased paperwork and utilization review contact

mandated by managed care. Additionally, therapeutic decisions formerly made by providers alone, are now being filtered by utilization reviewers whose credentials and qualifications they find lacking. Possibly respondents do not question credentials because of concerns about a backlash (denial of authorized sessions, etc.) they may encounter from the utilization reviewer who feels their authority is being questioned.

The impact of managed care on the mental health professionals was also found to be economic. Results in this study indicate that providers experienced a significant decline in referrals from primary care physicians. This coupled with patients terminating treatment prematurely, and fee reductions to maintain patient contact could lead to economic devastation for an independently practicing provider.

Further, frustration exhibited by mental health care provider responses may have arisen from a managed care mandate for short-term therapy. Consistent with the Austad study (1993), the majority of professionals surveyed assessed their effectiveness positively when using this method. However, the majority of practitioners agreed that short-term therapy was not suitable for most patients.

Unexpectedly, providers did not realize a reduction in referrals following an appeal to the

managed care organization. This result is inconsistent with findings by the APA Practice Directorate (1996) which reports that many psychologists are experiencing retaliation from managed care companies following appeal of patient care termination.

The failure to observe any significant managed care experience effects here is inconsistent with other research. The limited sample size may have obscured such effects.

The present findings suggest that clientele may mediate clinicians' attitude toward managed care. Managed health care providers who worked with more treatment resistant patients tended to express less overall negative attitudes toward managed care than those who worked more exclusively with worried well clients. At this point in its evolution, managed care may have had a greater influence on clinical practitioners who treat patients of less diagnostic severity, because it has denied treatment authorization in many of these cases.

An important aspect of this study would require further discussion. As no strong attitudinal differences regarding managed care were revealed between Ph.D.'s, M.D.'s and masters level psychologists, further investigation of the attitude of MSW's and those mental health care professionals working in institutional settings would be beneficial.

Clearly their addition to this field of professionals would broaden this study and encompass a more diverse population and experience level.

The questionnaire was developed to reflect the most common concerns expressed by mental health care providers regarding managed mental health care. As a result, this study may have been more sensitive to the problem areas.

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